**BOARD OF OPTOMETRY**
**2420 DEL PASO ROAD, SUITE 255, SACRAMENTO, CALIFORNIA, 95834**
**(916) 575-7170 / (866) 585-2666**

# CONSUMER COMPLAINT FORM

**FOR OFFICE USE ONLY**

CASE #_____
Action Taken _____
OD#_____

**Please Print or Type**

## PERSON REGISTERING COMPLAINT

| Name: | Home Phone |
|---|---|
| Address: | Business Phone |
| City / State / ZIP Code | |

I authorize the State Board of Optometry to provide a copy or summary of this complaint to the optometrist, and to obtain a copy of my patient records from the optometrist if necessary.

_____ _____
Signature Date

## COMPLAINT REGISTERED AGAINST

| Name of the optometrist: | |
|---|---|
| Address: | Business Phone |
| City: / State / Zip Code | |

## DETAILS OF COMPLAINT

1. Have you discussed this matter with the optometrist?

YES ☐ NO ☐

When:_____

Result:_____

_____

_____

_____

_____

2. Have you discussed this matter with your local optometric society, other organization or other eye care professional?

YES ☐ NO ☐

Whom:_____

_____

When: _____

Result: _____

_____

_____

_____

_____

_____

3. Have you contacted an attorney or filed a claim in Small Claims Court?

YES ☐ NO ☐

4. Date of eye examination and /or date of delivery of ophthalmic devices?

5. State the pertinent details of your complaint:

6. What would you consider to be a satisfactory resolution to your complaint?

7. I certify that all information which I have given herein to be true, correct and complete to the best of my knowledge.

Signature _____ Date _____

Please attach additional information or evidence you may have to support your allegation(s) to this form.